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Sentencing white coat crime: the need for guidance in medical manslaughter cases

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Case: [R. v Garg \(Sudhanshu\) \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(CA \(Crim Div\)\)](#)

**Crim. L.R. 871 Since the minimum term for murder was raised by the [Criminal Justice Act 2003](#), the Court of Appeal has held that sentences for all types of manslaughter should reflect Parliament's will that offences causing death should be punished more severely. This focus on harm rather than culpability has now been applied to gross negligence "medical" manslaughter cases ([Garg](#)). This article argues that the increasingly punitive approach of the court is flawed, calls for sentencing guidance to be issued to reflect the particular situation of medical practitioners and considers how this might be done.*

The relationship between healthcare and the criminal law has historically been neglected in practice and scholarship.¹ Recent developments have demonstrated both inadequacies in the criminal law regarding the harmful conduct that can be captured, together with an increasingly punitive sentencing policy for those who are convicted of unintentionally killing their patients.² The Inquiry into the mistreatment and neglect of patients in the Mid Staffordshire NHS Trust³ has highlighted some of the shortcomings of the criminal law regarding accidental deaths, injuries and neglect in clinical settings, and there have been calls for new legislation to criminalise a wider range of conduct, culpability and outcomes.⁴ As the law stands, charges can be brought solely for gross negligence manslaughter. If the patient is not killed, but merely demeaned, injured or incapacitated by mis-treatment, the law provides criminal sanction in only limited circumstances **Crim. L.R. 872* involving particularly vulnerable patients.⁵ Medical manslaughter does not exist as a discrete criminal offence but the Crown Prosecution Service (CPS) uses the term to refer to charges of gross negligence manslaughter against "medically qualified individuals who are performing acts within the terms of their duty of care, when the act or omission occurs."⁶ There are no sentencing guidelines in these cases but, following a line of appeals in other types of manslaughter cases, the Court of Appeal held in [Garg](#), that causing death in these circumstances will now result in lengthier sentences.⁷

Medical manslaughter cases have been described as "a development of the 1990s".⁸ Official statistics are not kept on these cases, and different methods have been used to capture the number of cases involved. In 1970, it was seen as "unlikely in the extreme" that a doctor would be charged with criminal negligence.⁹ There were seven reported prosecutions between 1867 and 1989,¹⁰ 17 between 1990 and 1999,¹¹ and 38 between 1995 and 2005.¹² Griffiths and Sanders question these data but agree that there has been an increase in coronial inquests and police investigations of suspicious medical deaths.¹³ This rise has been attributed to many factors, including a more litigious and less deferential culture, a growing "intolerance of accidents as innocent events [that] has tended to turn medical mistakes resulting in death into tragedies calling for criminal investigation,"¹⁴ and the creation of an independent prosecution authority.¹⁵ State obligations to investigate deaths under art.2 ("the right to life") of the European Convention on Human Rights (ECHR) may also have played a part.¹⁶ The numbers facing trial are still small however, between about one and four a year by most estimates,¹⁷ and a number of reasons for this have been advanced. There are practical problems with identifying these cases; deaths in medical settings are not necessarily suspicious and it may be difficult for colleagues to recognise or report their concerns. There are evidential challenges with establishing that a particular (in)action "more than minimally, negligibly or trivially contributed to the death" **Crim. L.R. 873*¹⁸ of an individual who may have been in poor health to start with.¹⁹ These cases often turn on the testimony of expert witnesses about the degree of negligence.²⁰ White-collar crime, committed by "a person of respectability and high social status in the course of his occupation"²¹ has long presented difficulties for the police. "White-coat" suspects present even greater

challenges—not only do they possess professional status and specialist expertise in the subject under investigation, but they usually have no malicious intention, have not acted for personal gain and often arouse sympathy. Prosecutors are aware that "judges and juries do not like having these cases (particularly involving doctors) in front of them".²²

Another challenge in bringing medical manslaughter charges is that "prosecutors, judges and juries all struggle with the ill defined concept of gross negligence".²³ It was held in [Adomako](#)²⁴ that the jury must consider: whether the defendant was in breach of a duty of care towards the victim; whether the breach caused the death of the victim; and, if so, whether, having regard to the risk of death involved, (not merely of serious injury),²⁵ the conduct of a defendant was so bad in the circumstances as to amount to a criminal act or omission.²⁶ The ordinary principles of the law of negligence apply in a medical setting in determining whether the duty of care owed to the deceased was breached, that is, whether the defendant "has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".²⁷ It is not necessary to show that there was any recklessness or disregard for the patient's welfare; the fact that the practitioner was doing his or her best, or was working in a department that was under-resourced, is not relevant.²⁸ What transforms simple negligence into its gross counterpart is far from clear, the definitions offered in the cases are "ambiguous and circular, and [are] likely to lead to inconsistencies in the verdicts".²⁹ Much of the academic debate around this subject has focused on these criticisms of the test for gross negligence manslaughter; whether conduct or its consequences should be judged³⁰; and considerations of alternative tests.³¹ Others have questioned whether medical practitioners should be subject to the criminal law for errors made in the course of their work, arguing that it is often the system that is as much at fault,³² and have raised concerns about the potential effects of a "blame culture" on clinical ***Crim. L.R. 874** practice.³³ Whether as a result of juror sympathy or the evidential hurdles, the conviction rate for medical manslaughter prosecutions is less than half that for manslaughter generally.³⁴ This may raise questions about the CPS policy in prosecuting so many cases that fail³⁵—although Griffiths and Sanders suggest that too few prosecutions are pursued.³⁶ However few in number, these cases are nevertheless important, not only to the defendant and those close to the deceased, but also to the health service and all those who use and work in it.

One area that has not been addressed in academia, policy or practice is the difficulties that judges face in passing sentence in medical manslaughter cases, due to the lack of precedent and the unhappy circumstances of sentencing those who are often "far from being bad men".³⁷ Until recently, sentences tended to be minimal,³⁸ or as one commentator styled it "the standard thing, you know, six months suspended."³⁹ This changed after [Garg](#),⁴⁰ the first appeal against sentence for medical manslaughter since the sentencing provisions of the [Criminal Justice Act 2003](#) (CJA 2003) came into force. This article examines some of the problems with the punitive way in which the courts have interpreted this legislation in relation to medical manslaughter. The Court of Appeal has emphasised the need for the sentence to reflect the seriousness of the death of an individual, but it is not clear that this policy follows the intentions of Parliament. [Garg](#) is not a guideline judgment,⁴¹ nevertheless, it is clear that there are general sentencing principles that could—and, in the interests of fairness, should—be articulated. In the absence of a change of approach by the Court of Appeal, or legislation from Parliament, it is argued that the Sentencing Council should consider issuing guidance for these cases, and some options are suggested.

Sentencing gross negligence manslaughter since the CJA 2003

[Section 5 of the Offences Against the Person Act 1861](#) provides a maximum sentence of life imprisonment for those convicted of manslaughter. Sentences for involuntary manslaughter cover the widest band of outcomes of any offence.⁴² There are no guideline cases for sentencing involuntary manslaughter generally,⁴³ but some principles and indications had emerged for specific "types" of case, such as "one-punch" manslaughter. The [CJA 2003](#) prescribed an increase in the severity of the minimum term to be passed for murder. The Court of Appeal interpreting this to mean higher sentences for manslaughter involving violence,⁴⁴ extended this ***Crim. L.R. 875** to gross negligence manslaughter,⁴⁵ then, in [Garg](#), held this applied in a medical context also.⁴⁶ It is argued below that this reasoning has caused excessive punishment of some offenders, whilst being inevitably insufficient to satisfy any retributive desires.

For those receiving the mandatory sentence of life imprisonment for murder, the judge has to recommend a "minimum term" that must be served before an offender can be considered for early release; this constitutes the punitive element of the sentence.⁴⁷ [Schedule 21 CJA](#) divides murders into four categories of seriousness and sets starting points for adults aged 21 and over of a whole life

order, 30, 25 and 15 years.⁴⁸ For a life-sentenced prisoner, the minimum term represents the time actually to be served in custody, whereas those given a determinate sentence are usually released on licence at the halfway stage.⁴⁹ This means that a 30-year term is the equivalent of a 60-year determinate sentence.

Although Parliament made no link between the minimum terms and sentencing decisions in manslaughter cases, the court observed in [Wood](#) :

"This reality cannot be ignored, and a vast disproportion between sentences for murder and the sentences for offences of manslaughter which can sometimes come very close to murder would be inimical to the administration of justice."⁵⁰

This would appear relatively uncontentious. Wood's conviction for "a prolonged murderous (... unprovoked) attack of repeated and utmost ferocity"⁵¹ was substituted on appeal for manslaughter by diminished responsibility due to alcohol dependency syndrome. His life sentence with a minimum term of 18 years was replaced by another life sentence with a minimum term of 13 years. Linking sentencing for manslaughter by diminished responsibility with [Sch.21](#), produced an apparently logical sentence for a mitigated murder. The lesser crime and shorter sentence already reflect the reduced culpability of the defendant; not to increase the minimum term in line with those passed for murder would mean the offender in effect receiving a further reduction. What has proved more troublesome is the court's questionable reasoning (explored below) that:

"We derive some further, indirect support to our approach from the stark reality that the legislature has concluded, dealing with it generally, that the punitive element in sentences for murder should be increased. This coincides with increased levels of sentence for offences resulting in death, such as causing death by dangerous driving and causing death by careless driving. Parliament's intention seems clear: crimes which result in death should be treated more seriously and dealt with more severely than before. Our conclusion is not governed by, but is consistent with, this approach. **Crim. L.R. 876* "⁵²

[Section 143\(1\) of the CJA 2003](#) provides that:

"In considering the seriousness of any offence, the court must consider the offender's culpability in committing the offence and any harm which the offence caused, was intended to cause or might foreseeably have caused."

For reasons that are not clear, the Court of Appeal has focused on the harm rather than culpability limb of this section. This is likely to be an issue in many sentencing decisions, but particularly so in some medical manslaughter cases. In [Appleby](#),⁵³ the leading case in sentencing for manslaughter, the court considered sentences for unlawful act manslaughter involving fighting in public. It held that the effect of the [CJA](#), in particular [s.143](#), renders inappropriate its previous approach⁵⁴ to sentencing these cases, in which criminality was assessed in the context of the offender's actions and intentions at the time of the offence rather than on the fatal consequences⁵⁵.

"What is now required, without of course diminishing the attention to be paid to the actions of the defendant and his intentions at the time, and the true level of his culpability, is that specific attention must also be paid to the consequences of his crime... In manslaughter, culpability may be relatively low, but the harm caused is always at the highest level."⁵⁶

The court emphasised that there should not be "any direct arithmetical connection" between the sentences for murder and manslaughter, noting that Parliament has clearly preserved the vital distinction between murder and manslaughter.⁵⁷ Crimes that result in death should be treated more seriously, not so as to equate the sentences, but rather to give greater weight to the fact that a victim has died in consequence of an unlawful act of violence.⁵⁸ The court considered the Sentencing Guideline Council's guidelines on manslaughter by reason of provocation and attempted murder. It referred also to the considerations relating to diminished responsibility in [Wood](#), and those applicable to deaths on the road. Whilst accepting that none of these was directly analogous with "one-punch" manslaughter cases, when considered with recent changes in the legislative structure, it came to the "inevitable conclusion" that it was Parliament's intention that crimes resulting in death should be treated more seriously.⁵⁹ In [Burridge](#), the court went on to hold that [Wood](#) and [Appleby](#) applied "equally to unlawful act manslaughter of babies and children as they do to disorder in the street".⁶⁰ [Draper](#),⁶¹ whilst relating to similar facts, extended the reasoning much further. It emphasised that this harsher approach **Crim. L.R. 877* to sentencing "is common to all cases of manslaughter, however they may arise and whatever their factual circumstances".⁶²

Each of the foregoing cases involved an unlawful act of violence, a factor the court thought significant in [Appleby](#) , but not by the time it considered [Draper](#) . This greater emphasis on the fatal consequences of a criminal act then led the court to conclude in [Holtom](#) that "... a similar consideration applies to cases of manslaughter by gross negligence in the work place".⁶³ Similarly in [Barrass](#) (a conviction for gross negligence manslaughter for a man who left his infirm sister lying on the floor in cold weather for two and a half weeks, following a fall) the court rejected the submission that [Appleby](#) applied only to "one-punch" manslaughter cases, rather it had created

"... a step change in the tariff of sentencing in such cases, each of which of course ultimately rests on its own particular facts, but in general by reference to a proper consideration of the... fatal consequences of the offences." ⁶⁴

Eventually in its development of this sentencing approach, the court came to consider a medical manslaughter case. Sudhanshu Garg, a consultant urologist and "a man of positive good character and a highly qualified medical practitioner"⁶⁵ was sentenced to two years' imprisonment following his guilty plea. An otherwise healthy young woman had been admitted to hospital via the Accident and Emergency Department on a Friday and died the following Monday. There were mistakes made in her transfer to the Urology ward, errors by other staff, and failures in communication. It was held that Mr Garg had placed too much reliance on the information provided by others involved in her care and that he had failed to identify and treat the patient's clinical condition adequately. Mr Garg took steps to conceal his neglect including falsifying the patient's medical records. He denied responsibility for gross negligence manslaughter, and gave inaccurate information in his police interviews. There was some debate as to the stage at which he pleaded guilty, but he was given full credit (one-third) for this at sentencing.

In upholding the sentence, the Court of Appeal accepted that the pre-[CJA 2003](#) cases showed that medical manslaughter cases were regarded as requiring more modest levels of punishment than other types of manslaughter. It gave no authority for this and did not say why or by how much the level should be reduced. It accepted that this differential should not be eroded or recalibrated but it made clear that the increased tariff should apply in these cases also⁶⁶:

"The decisions in [Holtom](#) and [Barrass](#) demonstrate that the principles enunciated in general terms in relation to sentencing in manslaughter cases in [Wood](#) and [Appleby](#) apply to cases involving gross negligence manslaughter generally. *There is no special exception when manslaughter occurs in the context of gross medical negligence.* *[Crim. L.R. 878](#) " ⁶⁷

The rationale for sentencing

Sentencing appeals in manslaughter cases following [Wood](#) and [Appleby](#) have focused on their applicability to different types of manslaughter. They have not sought to challenge the underlying rationale that the increased punitive element for murder and the increase in offences and sentences⁶⁸ for vehicular homicides showed that Parliament intended that all crimes resulting in death should be dealt with more severely. Yet this conclusion is questionable. The minimum terms for those receiving a mandatory life sentence might as plausibly be ascribed to political pique at the loss of ministerial power over the sentencing and release of life-sentenced prisoners, following a series of rulings that such involvement contravened art.6 of the ECHR.⁶⁹ It may be also that Parliament wanted to ensure that murderous behaviour was punished more severely, rather than any behaviour causing death. The legislature made no mention of sentences for manslaughter in the [CJA 2003](#), the Sentencing Council⁷⁰ did not increase the guideline sentences for other cases involving death following the Act, nor was it asked to consider this, and its guidance on overarching principles⁷¹ states that harm must always be judged in the light of culpability. This emphasis on culpability was dismissed in [Burridge](#)⁷² following an observation in [Appleby](#) that the Guidance was based on work that had begun before the [CJA 2003](#) —even though the point in [Appleby](#) was not clearly made in relation to this, and had concluded that the Council "was plainly aware of and referred to the [2003 Act](#)."⁷³

The court gave weight to the fact that in road traffic crime Parliament has attributed great importance to the consequence of the driving, whether dangerous or careless. It found particular significance in the creation of an offence of causing death by careless or inconsiderate driving,⁷⁴ one of the few examples of simple negligence forming the basis for criminal liability. The offence now has a higher maximum sentence than dangerous driving (without causing death), despite dangerous driving being more culpable conduct. Others have cautioned that "the law should not be held hostage by the peculiarities of road traffic negligences, and that the matter should be considered afresh for medical

negligence".⁷⁵ Road traffic offences have historically been dealt with leniently; the specific offence of causing death by reckless or dangerous driving was introduced because of the reluctance of juries to convict motorists of manslaughter.⁷⁶ There may also have been a reticence in prosecuting these cases.⁷⁷ The hierarchy of offences for negligent driving does not exist for gross negligence manslaughter. There is no "lesser included" offence for gross negligence manslaughter (unlike dangerous driving **Crim. L.R. 879* for death by dangerous driving). Some prosecutorial decisions are surprisingly generous; driving inappropriately closely to another vehicle or overtaking on the inside are still deemed only careless.⁷⁸ The lack of witnesses can make it difficult to establish the driver's degree of (in)attention.⁷⁹ In recent years, societal attitudes towards drink driving and speeding have hardened and the Sentencing Guidelines and new offences have reflected this. It is thus not necessarily the case that Parliament's desire to see greater punishment for those who cause death on the roads can be extrapolated to a medical setting.

The courts have to consider certain factors when determining sentence. [Section 142 of the CJA 2003](#) requires those passing sentence to take into account: [deserved] punishment, deterrence, incapacitation, rehabilitation, and reparation to victims; a "'smorgasbord' approach to sentencing aims".⁸⁰ It does not indicate what priority should be observed among these goals, but the increased emphasis on preventive aims has been attributed to the government's intention of focusing criminal justice reform on the more effective prevention of crime.⁸¹ This, already muddled, approach is even less clear in sentencing medical manslaughter cases:

"While the criterion of negligence is the very stuff of the civil law, it is immediately problematic in the context of criminal law. The negligent actor does not fit into traditional models of criminality... it is undeniable that the traditional rationale for criminal punishment is considerably weaker for the negligent actor."⁸²

The rationale for punishment may require different considerations for medical manslaughter cases. Although Hart suggests the threat of punishment might encourage greater caution,⁸³ this works only for cases of recklessness; "human error, being by definition unintentional, is not easily deterred".⁸⁴ Since Drs Prentice and Sullman were convicted for injecting vincristine into their patient's spine rather than vein, the same fatal error has been made at least 17 times.⁸⁵ Lengthier sentences would seem unlikely to have a deterrent effect on the inadvertent conduct of doctors who have a professional ethic to "abstain from harming or wronging any man".⁸⁶ Whilst their employers or medical defence organisations are likely to meet the financial costs of clinical negligence claims, doctors already face the deterrent of potentially career-ending disciplinary proceedings.⁸⁷ Notwithstanding their altruism, it is also "bad for any doctor's own professional advancement, **Crim. L.R. 880* smooth professional life, reputation and peace of mind to harm patients."⁸⁸ Whilst criminal proceedings bring unique strains and stigma, they are unlikely to provide a more effective deterrent in these cases.

Incapacitation ("the idea of simple restraint: rendering the convicted offender incapable, for a period of time, of offending again")⁸⁹ is not a relevant consideration in these cases. It would be wholly disproportionate to imprison doctors in order to prevent them from making further mistakes. Those practitioners who are sufficiently incompetent as to pose an on-going risk to their patients can be dealt with by their professional bodies who can erase, suspend or impose conditions on a doctor's registration in the interests of patient safety.⁹⁰ Reparation to the victim is obviously not possible. The goal of rehabilitation seems particularly ill served by a sentence likely to end the career of a highly skilled and expensively trained professional. As Dyer argued in relation to the Sullman and Prentice case:

"Bringing the full weight of the criminal law to bear on two fledgling doctors will do little to remedy a system which lets juniors loose on patients with too little training, too little support, and too little sleep."⁹¹

That leaves only punishment as a rationale for sentencing. A particular stigma attaches to criminal proceedings. As white-coat criminals

"in effect the punishment beyond that to the doctor's personal conscience [is] the trial itself and the ignominy of public pillory and professional discredit."⁹²

The bereaved may experience "the very human desire to punish human beings for causing death;"⁹³ a feeling which some have argued, "must not be under-valued, even if nothing other than its partial satisfaction is achieved by a criminal prosecution".⁹⁴ Smith has argued against such

"naked retribution—and a very crude form of retribution, the degree of punishment being based not on

the moral culpability but on the harm done." ⁹⁵

Whilst the views of the bereaved are increasingly a feature of investigation and prosecution decisions

"vengeance alone is not seen as appropriate in legal systems such as those of England... where it is usually accepted that punishment should be reserved for actions that are blameworthy. *Crim. L.R. 881" ⁹⁶

It should not be assumed that all those bereaved want retaliation. Many want an explanation, an apology, or remedial measures to reduce the chances of others suffering in the same way. ⁹⁷ Only 60 per cent of people suing doctors were motivated by a desire to ensure accountability. ⁹⁸ Whereas increases in the fixed terms for murder are sufficiently substantial to be meaningful (as the increase in the prison population has indicated), a two-year sentence is probably enough to effectively end the career of a doctor but not enough to satisfy any sense of vengeance, ⁹⁹ as the court appeared to acknowledge:

"The family will, we trust, realise that the sentence imposed by the court must not be compared to the value of the life lost, which was priceless." ¹⁰⁰

This results in a socially damaging sentence that satisfies nobody. Medical practitioners should not be above the law, nor immune from the consequences of their actions, ¹⁰¹ but it should not be beyond the capacity of the authorities to create a sentencing framework that reflects this spectrum of culpability and the particular circumstances in which doctors work.

Issuing guidance

Sentencing guidance has been issued in relation to a range of offences, by statute, the Court of Appeal, and the Sentencing Council, but gross negligence manslaughter has been omitted from this process. The court has noted that the value of general guidance in manslaughter cases "tends to be somewhat limited". ¹⁰² Sentences have been compared to previous ones, but the criteria are not clear or consistent. *Appleby* is one of the few decisions in which the court has expressed the hope that its judgment would assist in future sentencing decisions. It is disappointing that in *Garg* the court merely reiterated that it was not to be considered a guideline decision for medical manslaughter cases. ¹⁰³ Its decision reflected "specific individual features of the case" ¹⁰⁴ but gave little explanation as to how it had weighed these factors. In *Kovvali*, the sentence, which took the same three year starting point as *Garg* "was certainly within the appropriate range for offending of this nature" ¹⁰⁵ but the court made no attempt to delineate that spectrum. On the reported facts, ¹⁰⁶ *Kovvali*'s conduct might be thought more culpable than that of *Garg*, but the court thought *Crim. L.R. 882 that *Garg* had more aggravating features, ¹⁰⁷ namely gross negligence over a protracted period of time and the disposal and alteration of the deceased's medical records.

Many of the medical manslaughter cases involve tragic results from a "momentary error with no evidence of recklessness or disregard" ¹⁰⁸ by those of otherwise good character, who may be working in difficult conditions. This problem comes back to the definition of the offence, since gross negligence manslaughter has no requirement of recklessness. The blanket approach of the Court of Appeal in raising the sentences in all cases involving death misses important distinctions between these situations. In contrast, the *Sentencing Guideline for Causing Death by Driving* focuses on the behaviour of the defendant rather than the fact of the death of the victim. It appears to avoid the circularity of reasoning that the Court of Appeal has used to increase sentencing for gross negligence manslaughter cases and takes an approach, more akin to the previous one regarding "one-punch" cases ¹⁰⁹.

"Because the principal harm done by these offences (the death of a person) is an element of the offence, the factor that primarily determines the starting point for sentence is the culpability of the offender ... the central feature should be an evaluation of the quality of the driving involved and the degree of danger that it foreseeably created. These guidelines draw a distinction between those factors of an offence that are intrinsic to the quality of driving (referred to as "determinants of seriousness") and those which, while they aggravate the offence, are not.

¹¹⁰ All cases of medical manslaughter involve the greatest harm. If they are not all to attract the same sentence, then distinctions must be drawn between the conduct and culpability of the doctors convicted. Brazier and Alghrani identified a spectrum of behaviour in the Court of Appeal judgments:

"Drs Prentice and Sullivan [were] merely momentarily inadvertent. Dr Adomako was dreadfully incompetent. Dr Becker made an awful error in the heat of the moment. Drs Misra and Srivastava failed in their duty to their patient over a sustained period." ¹¹¹

Whilst the Court of Appeal has rejected the argument that gross negligence manslaughter should be confined to reckless manslaughter, ¹¹² this might be a useful basis for setting a sentencing framework. Merry and McCall Smith distinguish between errors (acts that unintentionally deviate from what is right) and violations (which attract moral culpability). Errors are unintentional, and can be made by good people. Experts can make them, they do not imply carelessness, the consequences are often dependent on luck and may be disproportionate to the size of the error, in part due to the nature of the activity. "Violations are characterized, *Crim. L.R. 883 at least to some extent, by *mens rea*." ¹¹³ Violations involve choice; they may predispose to error and make serious consequences more likely if error does occur. Some violations are routine, tolerated as normal and may be encouraged by those in authority (this may make some violations less culpable). They argue that the moral implications of the harm are different if there is a degree of choice in the action; those choosing to perform a reckless act are more deserving of blame. ¹¹⁴

Over a range of judgments, certain factors have emerged, not all of which are relevant in medical manslaughter cases (such as whether the death took place in the context of another offence). ¹¹⁵ Whilst acknowledging that there can be a spectrum of behaviour, the court has, of course, attempted to set guidelines in "one-punch" manslaughter, ¹¹⁶ and has identified aggravating factors in other cases. ¹¹⁷ These, together with the Sentencing Council guidance, can form a useful starting point.

In assessing seriousness in relation to causing death by dangerous driving, the Sentencing Council considers five factors: awareness of risk, effect of alcohol or drugs, inappropriate speed of vehicle; seriously culpable behaviour of the offender (such as using a hand held mobile telephone) and failing to have proper regard for the victim. The Guidelines set three levels of seriousness with sentencing ranges from 7–14 years' custody; 4–7 years' custody; and 2–5 years' custody (with an indication that in "markedly less culpable" cases, reference should be made to the upper level of causing death by careless driving (36 weeks–3 years' custody). These categories do not necessarily translate into a clinical setting but, with a little work, could be made to do so. Factors can also be drawn from the Sentencing Council's *Guidance Regarding Corporate Manslaughter and Health and Safety Offences Causing Death*. ¹¹⁸ Some of these factors are considered below, together with how they could be applied to medical manslaughter cases.

Awareness of risk

In *Dudley*, ¹¹⁹ the court commented that an awareness on the part of the offender that his act was dangerous could amount to a matter of aggravation for sentencing purposes. Of all the factors, it is this one that requires the most careful distinction for medical practitioners, as "many medical procedures... are inherently complex, difficult, and risky". ¹²⁰ Doctors operate in a risky situation rather than choosing to create a hazard as others, such as drivers, do. Doctors also have less choice than others in relation to risk-taking: *Crim. L.R. 884

"A surgeon cannot usually refuse to operate; risk (even risk of death) is an inherent part of medicine. Judgements have to be made instantly. The risk averse doctor may do more harm than good." ¹²¹

Doctors who are asked to perform a task which is beyond them should of course ask for help, but this may not always be practicable. ¹²² (See Merry and McCall Smith regarding the normalisation of violations.) It might be more useful to distinguish between awareness of risk (which would encompass most activities of medical staff) and recklessness towards risk. This may in part already happen, as it was a feature in each of the four cases that led to prosecutions in the Griffiths and Sanders' study. ¹²³

Previous character/remorse

The previous good character of the defendant

"is a common feature of offences of this sort [gross negligence manslaughter]. It is often an offence committed by a hard-working, law-abiding person who is not normally seen in the criminal courts." ¹²⁴

In a medical setting, almost all defendants should be of previous good character. It might thus be more appropriate to reverse this test to make it an aggravating factor if the defendant has previously

made similar errors or been warned about his or her conduct.¹²⁵ In vehicular homicides, evidence of previous exemplary driving will be considered in mitigation, particularly where the driver is a member of the emergency services. The guidance particularly draws attention to a good driving record, giving assistance at the scene and remorse. In a medical context, equivalent considerations are likely to favour senior staff. Driving requires a much narrower set of skills than medicine and, other than in exceptional circumstances, such as extreme weather, a newly qualified, responsible driver is not at a significant disadvantage to the veteran. An inexperienced doctor is more likely to face unforeseen events and thus to make mistakes and obviously cannot have a good record. Dr Mulhem was three days into his first post as a specialist registrar; Dr Hazari, (who was acquitted) was a 23-year-old pre-registration house officer who was six weeks into his first job.¹²⁶ The reduced sentences available for juveniles reflect the view that young offenders are less responsible, and therefore less culpable, for their actions;¹²⁷ perhaps allowance should thus be made in sentencing the inexperienced doctor.

It might likewise be assumed—for any kind of gross negligence manslaughter—that the defendant would feel remorse and thus its absence might be more appropriate as an aggravating factor, rather than its presence a source of **Crim. L.R. 885* credit. Some consideration would need to be given to due process protections for defendants (it is concerning that the judge in sentencing Dr Kovvali reduced the credit for the guilty plea because it had been delayed pending an expert report). Doctors should be no less entitled than other defendants to put the prosecution to proof, but their failure to cooperate with non-criminal enquiries could be considered an aggravating factor. In considering Garg's sentence, the court made no reference to his having been untruthful in his account to the police. It held that his attempt to alter the records in the hope of evading responsibility was "a serious matter of aggravation,"¹²⁸ but the court gave no explanation of the quantum by which this increased the sentence. Such behaviour should be charged as a separate offence,¹²⁹ in the interests of fair labelling, given the low rates of conviction for gross negligence manslaughter and to avoid the jury conflating the two issues.

Alcohol or culpably impaired judgement

If a medical practitioner is working under the influence of drugs or alcohol, then it is uncontroversial to state that this is an aggravating factor. As the court drily observed:

"It is not given to everyone to be a skilful surgeon, but it is given to everyone to keep sober when such a duty has to be performed."¹³⁰

Fatigue presents particular issues for medical manslaughter. Following the Selby Rail crash, the courts have taken a more serious view of driving whilst fatigued.¹³¹ Drivers who get behind the wheel or continue driving knowing they are too tired to concentrate are deemed more culpable, particularly where "commercial concerns" had a bearing on this¹³² but it seems wrong to hold medical staff to this standard when they are expected to work without the statutory protections around rest breaks that HGV drivers have¹³³ and, in practice, are rarely able to say that they are too tired to work safely. Mr Garg had been on call for eight days and came in late on the day his patient died, having had little sleep. The court noted the submission that

"there was evidence that this work-regime of sleeplessness and stress would affect the judgement of even the most robust practising clinician."¹³⁴

It did not clarify, however, whether it regarded this as aggravating or mitigating. It may be particularly difficult to judge the effects of fatigue in a hospital setting, where the adrenaline produced during emergencies may enable medical staff to function adequately for short periods. There are arguably differences between those who are tired because of the pressures of their employment; due to everyday **Crim. L.R. 886* situations (insomnia, young children, or noisy neighbours); and those who have chosen to do something (particularly for financial gain) knowing that it will make them too tired to work. Adomako had another full time job in a different hospital and had had only three and a half hours sleep the night before the fatality.

Duration

The duration of the mistake needs further consideration when applied in a clinical setting. The court in [Garg](#) held that the prolonged nature of his negligence was "the essential feature of culpability" and an aggravating factor. There is an important difference between doing something one knows to be wrong repeatedly or over a long period, and unwittingly repeating an error. Hussain¹³⁵ drove for over a mile

with his victim being dragged along under the vehicle. Although this would have taken only a couple of minutes, this is much more blameworthy than Garg's prolonged and compounded errors over a three-day period.

The responsibility of others

The Sentencing Guidelines for Causing Death by Driving provide that the contributory actions of others should be regarded as a mitigating factor. In *Roberts*,¹³⁶ the court considered that the offender was not solely responsible for the servicing of the lorry which he drove with defective brakes. In *Shaw*,¹³⁷ the judge accepted that others bore a degree of responsibility for having disabled the safety device on a stone cutting machine; whilst this did not relieve the offender of his responsibility, it put his criminal negligence into context. The Court of Appeal took a much less sympathetic view in *Garg* where many of the crucial errors were made by others, and the department was described as dysfunctional. Whilst acknowledging the force of the submission that Mr Garg was by no means the only person involved who had failed to exercise proper professional care of the patient, the court said merely:

"Although we understand the complexity of the environment which obtains in a large hospital ward of this kind, the appellant was negligent in his capacity as the head of the team of medical practitioners...he was in charge of the team responsible for her care, and his responsibility went far beyond mere failures of oversight and supervision of those for whose work he was responsible."¹³⁸

This requires explication: whilst Mr Garg's failures were judged to have been grossly negligent, it is unclear if the court is suggesting that his criminal liability should extend to the failures of others or that his punishment should be increased to reflect this. This seems very different to a case such as *Kite*,¹³⁹ who was sentenced to two years imprisonment for failing to ensure adequate safety precautions were taken by his employees when taking children out canoeing. Mr Kite's duty was to **Crim. L.R. 887* ensure the safety precautions were in place; a relatively formulaic task that can be monitored at predictable times. A senior doctor has supervisory responsibility for his or her team, but cannot be expected to check every detail and may have to rely on the work of colleagues (in Mr Garg's case, for instance, the staff who did not tell him about the patient's low blood pressure).¹⁴⁰

Conclusion

The (mis)treatment of patients at Mid Staffordshire NHS Trust in which "many suffered horrific experiences that will haunt them and their loved ones for the rest of their lives"¹⁴¹ raised the problem again of the remit of the criminal law in this area.¹⁴² Whilst an offence of "death by dangerous doctoring"¹⁴³ seems unnecessary, doctors are in an almost uniquely vulnerable position regarding prosecution for making a mistake. If errors of inadvertence are to face the full weight of the criminal law, then policy decisions need to be considered about prosecuting and sentencing such cases.

Doctors are not above the law but: "It is this vulnerability to prosecution for fatal errors that distinguishes health professionals from most of their professional peers."¹⁴⁴ There are some analogies with commercial drivers and pilots but these are imperfect due to the different working conditions and the team nature of treating patients. Discretion and luck play a significant part in the way in which cases of medical manslaughter are dealt with. First, in whether or not the patient dies, bringing the doctor within the ambit of the criminal law; whether anything untoward is noticed or reported; whether the authorities investigate and prosecute, and the testimony of the expert witnesses. Perceptions may play a part in this: the bereaved may be more inclined to accept the reassurances of a middle-aged, male, native English speaker that he had done everything possible for the deceased. Relatives, hospitals, police, prosecutors, experts and jurors may be less kindly disposed towards the young, inexperienced practitioner whose spoken English is less assured. (Over 50 per cent of prosecutions for medical manslaughter are of non-white practitioners, who comprise around 25 per cent of hospital doctors.)¹⁴⁵ It is for others to investigate these discrepancies, which may have many causes, but, in the interim, the sentencing policy of the courts should be made more transparent in order to reduce replicating disadvantage.

CPS Policy has not been considered here but, if it were decided that it was not in the public interest to prosecute those causing deaths by errors (rather than violations), this could obviate the need for such guidance. There are no Charging Standards for gross negligence manslaughter, as there are for vehicular homicides. Quick has argued that as the courts upheld Debbie Purdy's request for the **Crim. L.R. 888* publication of prosecutorial policy in relation to assisted suicide,¹⁴⁶ then medical

practitioners should not be denied the same for gross negligence manslaughter.¹⁴⁷

Parliament legislated in order to increase the punitive element in the mandatory life sentence for murder; it made no attempt to do so for manslaughter—perhaps reflecting the even greater range of conduct embraced by this charge. Sentencing involuntary manslaughter cases is difficult: "There is nowhere else in English criminal law where one crime stretches to encompass such a vast range of moral blame for the resulting harm,"¹⁴⁸ but the problem with medical manslaughter sentences is that the court has focused too much on the harm rather than the culpability. The court has (arguably mis) interpreted the [CJA 2003](#) in a manner that allows no exceptions to the policy of increased punitiveness. Whilst claiming that manslaughter cases are too particularised to bear sentencing guidelines, the new sentencing approach of the courts has caused unfairness by ignoring the individual elements of culpability, focusing only on the harm element that all these cases share. This has resulted in devastating consequences for some defendants, who are punished far beyond their culpability. Yet this satisfies no one, as the sentences can in no way reflect the harm caused.

Thomas has argued that: "A manifestly excessive sentence is no less a miscarriage of justice than an unsafe conviction".¹⁴⁹ It would however, be difficult for the Criminal Cases Review Commission to refer sentences such as [Garg](#), as it is unlikely to consider that there is a real possibility that the sentence would not be upheld, based on a new argument on a point of law or information not raised in the proceedings.¹⁵⁰

This appears to be a developing area of law with singular characteristics. Cooper points out the advantages of having guidelines, both to the defence (by allowing an informed plea to be entered having "a reasonable and educated expectation of the consequences") and to the Crown which has the responsibility of managing the expectations of the bereaved.¹⁵¹ There may be some practical and political tensions around the Sentencing Council providing guidance that contradicts authoritative judgments by the Court of Appeal. [Wood](#) and [Appleby](#) were five-judge constitutions led by the Lord Chief Justice, who is also President of the Sentencing Council. These should not be insurmountable, however. If the men and women in white coats are going to be put away, given the costs to the them, the criminal justice system and the National Health Service against the questionable benefits of imprisonment, there needs to be calibrated guidelines and a coherent rationale, not a one-size fits all increase in sentences for all manslaughter cases.

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1. D. Griffiths and A. Sanders, "Introduction" in D. Griffiths and A. Sanders (eds), *Medicine, Crime and Society* (Cambridge: Cambridge University Press, 2012), p.2.

2. [Garg \[2012\] EWCA Crim 2520: \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#); [Kovvali \[2013\] EWCA Crim 1056](#).

3. Chaired by Robert Francis QC, *Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)*, available at: <http://www.midstaffspublicinquiry.com> [Accessed August 20, 2013].

4. "...Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow..." Francis, *Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)*, Vol.3, p.1439, Recommendation 28. See also, A. Alghrani, M. Brazier, A.M. Farrell, D. Griffiths and N. Allen, "Healthcare scandals in the NHS: Crime and Punishment" (2011) 37(4) J Med Ethics 230.

5. Prosecutions can be brought for ill-treatment or wilful neglect but only if a patient is either being treated or cared for as a result of a mental disorder ([Mental Health Act 1983 s.127](#)), lacks mental capacity ([Mental Capacity Act 2005 s.44](#)) or is under 16 ([Children and Young Persons Act 1933 s. 1\(1\)](#)). Charges under the [Offences Against the Person Act 1861](#) are theoretically possible but usually require a degree of intention or subjective recklessness that is often absent in these cases.

6. CPS *Legal Guidance, Homicide: Murder and Manslaughter*, available at: http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/ [Accessed August 20, 2013]. The term "doctor" is used in this article for convenience but the arguments are applicable to other medical staff.

7. This was endorsed in [Kovvali \[2013\] EWCA Crim 1056](#).
8. C. Dyer, "Doctors Face Trial for Manslaughter as Criminal Charges Against Doctors Continue to Rise" (2002) 325 B.M.J. 63.
9. J. L. Taylor, *The Doctor and the Law* (London: Pitman Medical, 1970).
10. J. Holbrook, "The Criminalisation of Fatal Medical Mistakes" (2003) 327 B.M.J. 118.
11. R.E. Ferner, "Medication Errors that Have Led to Manslaughter Charges" (2000) 321 B.M.J. 1212.
12. R.E. Ferner and S.E. McDowell, "Doctors Charged with Manslaughter in the Course of Medical Practice, 1795-2005: A Literature Review" (2006) 99 Journal of the Royal Society of Medicine 309.
13. D. Griffiths and A. Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p.135.
14. Holbrook, "The Criminalisation of Fatal Medical Mistakes" (2003) B.M.J. 327, 118.
15. A. McCall-Smith, "Criminal Negligence and the Incompetent Doctor" (1993) 1 Medical Law Review 336; Lord Woolf, "Are the Courts Excessively Deferential to the Medical Profession?" (2001) 9 Med. L.R. 1.
16. Griffiths and Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p.120.
17. O. Quick, "Prosecuting "Gross" Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service" (2006) 33 Journal of Law and Society 421; M. Devlin "When an Error Becomes a Crime" (2010) 26 Medical Defence Union Journal 7, 7–8. Griffiths and Sanders "The Road to the Dock" (2012).
18. [HM Coroner for Inner London South District Ex p. Douglas-Williams \[1999\] 1 All E.R. 344 at 350; \(1998\) 162 J.P. 751 CA](#).
19. Forty four per cent of the CPS files examined by Griffiths and Sanders were not prosecuted due to difficulties in establishing causation ("The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p.140).
20. O. Quick, "Expert Evidence and Medical Manslaughter: Vagueness in Action" (2011) 38 Journal of Law and Society 496.
21. E.H. Sutherland, *White Collar Crime* (New York: Dryden Press, 1949).
22. Griffiths and Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p.135.
23. Griffiths and Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p.1.
24. [Adomako \[1995\] 1 A.C. 171; \[1994\] 3 W.L.R. 288](#).
25. [Misra \[2004\] EWCA Crim 2375; \[2005\] 1 Cr. App. R. 21 \(p.28\)](#).
26. [Adomako \[1995\] 1 A.C. 171; \[1994\] 3 W.L.R. 288](#).
27. [Bolam v Friern Hospital Management Committee \[1957\] 1 W.L.R. 582; \[1957\] 2 All E.R. 118](#).
28. [Wilsher v Essex AHA \[1987\] Q.B. 730; \[1987\] 2 W.L.R. 425](#). See also [Adomako \[1994\] Q.B. 302; \[1993\] 4 All E.R. 935](#) at 944.
29. B. Mitchell and R.D. MacKay, "Investigating Involuntary Manslaughter: An Empirical Study of 127 Cases" (2011) 31 O.J.L.S. 165, 166.
30. O. Quick, "Medicine, Mistakes and Manslaughter: A Criminal Combination?" (2010) 69 C.L.J. 186.
31. M. Brazier and A. Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25 Journal of Professional Negligence 51.
32. A. Harvey, "Doctors in the dock: Criminal liability for negligent treatment resulting in the death of a patient" (1994) 16(2) Liverpool Law Review 201.
33. A. Elias-Jones, "Medical Manslaughter or Systems Failure" (2004) 10 Clinical Risk 29; A. Merry and A. McCall Smith, *Errors, Medicine and the Law* (Cambridge: Cambridge University Press, 2001).
34. Between 1970 and 2002, of the 27 doctors charged, 41% were convicted (30% if the successful appeals are

discounted.) Home Office figures show that 238 of the 278 defendants (85%) who stood trial for manslaughter in 2001, were convicted (Dyer, "Doctors face trial for manslaughter" (2002) 325 B.M.J. 63).

35. A. Merry, "When are Errors a Crime?—Lessons From New Zealand" in C. Erin and S. Ost (eds), *The Criminal Justice System and Health Care* (Oxford: Oxford University Press, 2007), p.83.
36. Griffiths and Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), *Medicine, Crime and Society* (2012), p. 156.
37. The trial judge sentencing Drs Sullman and Prentice, quoted in Brazier and Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25 *Journal of Professional Negligence* 51, 56.
38. M. Brazier, *Medicine, Patients and The Law*, 2nd edn (London: Penguin, 1992), p. 138.
39. M.J. Powers, "Manslaughter—How Did We Get Here?" (2005) 73 *Medico-Legal Journal* 123.
40. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#).
41. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [6].
42. [Boyer \(1981\) 3 Cr.App.R. \(S.\) 35](#) at 37.
43. *Current Sentencing Practice I*, B1-32001.
44. [Wood \[2009\] EWCA Crim 651; \[2010\] 1 Cr. App. R. \(S.\) 2 \(p.6\)](#) at [19].
45. [Holtom \[2010\] EWCA Crim 934; \[2011\] 1 Cr. App. R. \(S.\) 18 \(p.128\)](#).
46. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#).
47. *Murder (Abolition of Death Penalty) Act 1965 s.1(1)*.
48. For 18–20 year olds there are three starting points of 30, 25 and 15 years'. Youths have a starting point of 12 years' detention at Her Majesty's Pleasure.
49. [Criminal Justice Act 2003 s.244](#) (sentences of 12 months or more); [Legal Aid, Sentencing and Punishment of Offenders Act 2012 s.111](#) and [CJA 2003 s.243A](#) for sentences of less than 12 months.
50. [Wood \[2009\] EWCA Crim 651; \[2010\] 1 Cr. App. R. \(S.\) 2 \(p.6\)](#) at [19].
51. [Wood \[2009\] EWCA Crim 651; \[2010\] 1 Cr. App. R. \(S.\) 2 \(p.6\)](#) at [3].
52. [Wood \[2009\] EWCA Crim 651; \[2010\] 1 Cr. App. R. \(S.\) 2 \(p.6\)](#) at [23].
53. [Attorney General's Reference \(Nos 60, 62 and 63 of 2009\) \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) ([Appleby](#)). Appleby was convicted of murder. His minimum term of nine years, reduced to six, on reflection by the trial judge, was assessed in relation to his co-accused, who was convicted of manslaughter and sentenced to 30 months' detention. The Court of Appeal held that a nine year sentence was the "absolute minimum appropriate sentence" at [44]. It refrained from increasing the sentence only because this was the third time the appellant had been sentenced for this offence.
54. [Coleman \[1992\] 95 Cr.App.R. 159 CA](#).
55. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [22].
56. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [13]-[14].
57. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [16].
58. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [22].
59. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [21].
60. [BurrIDGE \[2010\] EWCA Crim 2847; \[2011\] 2 Cr. App. R. \(S.\) 27 \(p.148\)](#) at [139].
61. [Attorney General's Reference \(No. 125 of 2010\) \[2011\] EWCA Crim 640; \[2011\] 2 Cr. App. R. \(S.\) 97 \(p.534\)](#) ([Draper](#)).
62. [Draper \[2011\] EWCA Crim 640; \[2011\] 2 Cr. App. R. \(S.\) 97 \(p.534\)](#) at [34].
63. [Holtom \[2010\] EWCA Crim 934; \[2011\] 1 Cr. App. R. \(S.\) 18 \(p.128\)](#) at [19].
64. [Barrass \[2011\] EWCA Crim 2629; \[2012\] 1 Cr. App. R. \(S.\) 80 \(p.450\)](#).

65. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [2].
66. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [42].
67. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [45], emphasis added.
68. The maximum sentence for causing death by dangerous driving has been steadily increased from two years' imprisonment to 14 years' imprisonment.
69. [T v United Kingdom \(2000\) 30 E.H.R.R. 121](#); [Stafford v United Kingdom \(2002\) 35 E.H.R.R. 32](#) and [R. \(on the application of Anderson\) v Secretary of State for the Home Department \[2002\] UKHL 46; \[2003\] 1 A.C. 837](#).
70. Its Guidance on Attempted Murder related aggravating factors to those in [CJA 2003 Sch.21](#), but did not explicitly link the sentences.
71. The *Sentencing Guidelines Council, Overarching Principles—Seriousness (2004)*, para 1.7.
72. [BurrIDGE \[2010\] EWCA Crim 2847; \[2011\] 2 Cr. App. R. \(S.\) 27 \(p.148\)](#) at [140].
73. [Appleby \[2009\] EWCA Crim 2693; \[2010\] 2 Cr. App. R. \(S.\) 46 \(p.311\)](#) at [18].
74. [Road Traffic Act 1988 s.2B](#), (as amended by [Road Safety Act 2006 s.20](#)); also causing death by careless driving when under the influence of drink or drugs ([Road Traffic Act 1988 s.3A](#)).
75. M. Hor, "Medical Negligence: The Contours of Criminality and the Role of the Coroner" [1997] *Singapore Journal of Legal Studies* 86.
76. *Department of Transport and Home Office, Road Traffic Law Review Report (1988) (North Report)*, p.51.
77. [Seymour \[1983\] 2 A.C. 493](#) at 502.
78. CPS Legal Guidance, *Road Traffic Offences - Guidance on Charging Offences arising from Driving Incidents*, available at: www.cps.gov.uk/ [Accessed August 20, 2013].
79. S. Cunningham, "Punishing Drivers who Kill: Putting Road Safety First" (2007) 27(2) *Legal Studies*, 288, 295; S. Cunningham, "The Unique Nature of Prosecutions in Cases of Fatal Road Traffic Collisions" [2005] *Crim. L.R.* 834.
80. A. von Hirsch and J.V. Roberts, "Legislating sentencing principles: the provisions of the [Criminal Justice Act 2003](#) relating to sentencing purposes and the role of previous convictions" [2004] *Crim. L.R.* 639, 641.
81. Von Hirsch and Roberts, "Legislating sentencing principles" [2004] *Crim. L.R.* 641, 641–642.
82. Hor, "Medical Negligence" [1997] *Singapore Journal of Legal Studies* 86, 87–88.
83. H.L.A. Hart, *Punishment and Responsibility (Oxford: Clarendon Press, 1968)*, Ch.VI
84. *Merry and McCall Smith, Errors, Medicine and the Law (2001)*, p.2.
85. D. Griffiths, A. Alghrani, and M. Brazier, "'Medical Manslaughter': A Cause for Concern?" (2010) 26 *M.D.U. Journal* 11.
86. Hippocratic Oath.
87. Mr Garg was sacked by his employers in 2009, *Dyer "Urologist is Jailed" [2012] B.M.J. 344*. On August 1, 2013 a decision was taken to suspend Mr Garg from the Medical Register for a period of 12 months. The trial judge in Mulhem "specifically indicated that he took into account as a matter of mitigation of penalty that he was to impose the fact that Dr Mulhem would lose his profession" [R. \(on the application of the Council for the Regulation of Healthcare Professionals\) v General Medical Council \[2004\] EWHC 3115 \(Admin\)](#) at [16].
88. Merry, "When are Errors a Crime?" (2008) in Erin and Ost (eds), *The Criminal Justice System and Health Care (2007)* p.95
89. A. von Hirsch and A. Ashworth (eds), *Principled Sentencing: Readings on Theory and Policy, 2nd edn (Oxford: Hart Publishing, 1998)*, p.88.
90. *General Medical Council, Regulating Doctors: Ensuring Good Medical Practice. Indicative Sanctions Guide for the Fitness to Practise Panel (April 2009)*, available at: http://www.mpts-k.org/static/documents/content/Indicative_Sanctions_Guidance_April_2009.pdf_28443340.pdf.
91. C. Dyer, "Manslaughter Convictions for Making Mistakes" (1991) 303 *B.M.J.* 1218.
92. S. Levy, "Gross Negligence Manslaughter: Drawing the line: medical practitioners and manslaughter" (2004) *AVMA Medical and Legal Journal* 31, 32.

93. P. Matthews, "Involuntary Manslaughter: A View From the Coroner's Court" (1996) 60 J. Crim. L. 189, 198, citing *LCCP, para.5.35 Law Commission, Murder, Manslaughter and Infanticide (2006), Law Com. No.304.*
94. S. Dyer, "Gross Negligence Manslaughter: The Facts of R v Mulhem" (2004) 10 AvMA Medical & Legal Journal 28.
95. J.C. Smith, "The Element of Chance in Criminal Liability" [1971] Crim. L.R. 63, 73.
96. Merry, "When are Errors a Crime?" (2008) in Erin and Ost (eds), *The Criminal Justice System and Health Care (2007)*, p.2.
97. J. Allsop, "Regaining Trust in Medicine: Professional and State Strategies" (2006) 54 Current Sociology 621; Woolf, "Are the Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1, 15.
98. C. Vincent, M. Young and A. Phillips, "Why do people sue doctors? A study of patients and relatives taking legal action" (1994) 343(8913) *The Lancet* 1609.
99. See "Anger as fatal jab doctor freed" after Dr Mulhem was sentenced to eight months' imprisonment, *BBC News*, September 23, 2003, available at: <http://news.bbc.co.uk/1/hi/health/3133076.stm> [Accessed August 20, 2013].
100. [Holtom \[2010\] EWCA Crim 934; \[2011\] 1 Cr. App. R. \(S.\) 18 \(p.128\)](#) at [15].
101. Although some argue that the criminal law is not appropriate in the context of medical mistakes, see J. Montgomery, "Medicalising Crime — Criminalising Health? The Role of Law" in Erin and Ost (eds), *The Criminal Justice System and Health Care (2007)*.
102. [Attorney General's Reference \(No.111 of 2006\) \[2006\] EWCA Crim 3269; \[2007\] 2 Cr. App. R. \(S.\) 26 \(p.146\)](#) (Hussain). See also [Roys \[2008\] EWCA Crim 2021; \[2009\] 1 Cr. App. R. \(S.\) 91 \(p.538\)](#); [Boyer \(1981\) 3 Cr. App. R. \(S.\) 35](#); [Johnson \[2008\] EWCA Crim 2976; \[2009\] 2 Cr. App. R. \(S.\) 28 \(p.210\)](#).
103. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [6]. A point noted in [Kovvali \[2013\] EWCA Crim 1056](#) at [17].
104. [Garg \[2012\] EWCA Crim 2520; \[2013\] 2 Cr. App. R. \(S.\) 30 \(p.203\)](#) at [6].
105. [Kovvali \[2013\] EWCA Crim 1056](#) at [20] and [21].
106. The doctor missed what were "so clearly and obviously the classic signs of a diabetic condition; a blood sugar test was the obvious step and would have taken a matter of minutes; the necessary equipment was available but the appellant was not prepared to go to his car to collect his medical bag; the risk of death was so obviously foreseeable if no steps were taken to address the symptoms".
107. [Kovvali \[2013\] EWCA Crim 1056](#) at [17].
108. [Becker Unreported June 19, 2000 CA \(WL 877688\)](#).
109. [Furby \[2005\] EWCA Crim 3147; \[2006\] 2 Cr. App. R. \(S.\) 8 \(p.64\)](#).
110. *Sentencing Guidelines Council, Causing Death by Driving (2008)*, p.2.
111. Brazier and Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25(2) *Journal of Professional Negligence* 51, 59.
112. [Misra \[2004\] EWCA Crim 2375; \[2005\] 1 Cr. App. R. 21 \(p.28\)](#) at [55].
113. Merry, "When are Errors a Crime?" in Erin and Ost (eds) *The Criminal Justice System and Health Care (2008)*, p.89.
114. Merry and McCall Smith, *Errors, Medicine and the Law (2001)*, p.73. See Quick, "Medicine, Mistakes and Manslaughter" (2010) 69 C.L.J. 186, 199.
115. [Hussain \[2006\] EWCA Crim 3269; \[2007\] 2 Cr. App. R. \(S.\) 26 \(p.146\)](#).
116. [Coleman \[1992\] 95 Cr. App. R. 159 CA; \[2005\] EWCA Crim 3147; \[2006\] 2 Cr. App. R. \(S.\) 8 \(p.64\)](#).
117. [Johnson \[2008\] EWCA Crim 2976; \[2009\] 2 Cr. App. R. \(S.\) 28 \(p.210\)](#) at [11].
118. *Guidance Regarding Corporate Manslaughter and Health and Safety Offences Causing Death (2010)*, available at: <http://sentencingcouncil.judiciary.gov.uk/> [Accessed August 20, 2013].
119. [Dudley \[2006\] EWCA Crim 387; \[2006\] 2 Cr. App. R. \(S.\) 77 \(p.514\)](#).
120. Merry, "When are Errors a Crime?" in Erin and Ost (eds), *The Criminal Justice System and Health Care (2007)*, p.88.
121. M. Brazier and N. Allen, "Criminalising Medical Malpractice" in Erin and Ost (eds), *The Criminal Justice System and*

- Health Care* (2007), p.21.
122. McCall-Smith, "Criminal Negligence the Incompetent Doctor" (1993) 1 *Medical Law Review* 336, 338.
123. *Griffiths and Sanders, "The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases" in Griffiths and Sanders (eds), Medicine, Crime and Society* (2012).
124. *Holtom [2010] EWCA Crim 934; [2011] 1 Cr. App. R. (S.) 18 (p.128)* at [13].
125. *Kovvali [2013] EWCA Crim 1056*. Also seen as relevant in a non-medical context in *Draper [2011] EWCA Crim 640; [2011] 2 Cr. App. R. (S.) 97 (p.534)*.
126. Holbrook, "The Criminalisation of Fatal Medical Mistakes" (2003) 327 *B.M.J.* 118.
127. *Ghafoor [2002] EWCA Crim 1857; [2003] 1 Cr. App. R. (S.) 84 (p.428)* at [17]. See also *Sentencing Guidelines Council, Overarching Principles - Sentencing Youths: Definitive Guideline* (2009).
128. *Garg [2012] EWCA Crim 2520; [2013] 2 Cr. App. R. (S.) 30 (p.203)* at [47].
129. *Adomako* was also charged with—but acquitted of—two counts of perjury relating to evidence he gave at the coroner's inquest. Ferner detailed a case in which a doctor was also charged under the [Forgery and Counterfeiting Act 1981](#) for altering the patient's records (Ferner, "Medication Errors That Have Led to Manslaughter Charges" (2000) 321 *B.M.J.* 1212).
130. *Doherty* (1887) 16 *Cox CC* 306 at 309.
131. Hart [2003] *EWCA Crim* 1268.
132. *Sentencing Guidelines Council, Causing Death by Driving* (2008), para.A(i)8(o); *Oughton [2010] EWCA Crim 1540; [2011] 1 Cr. App. R. (S.) 62 (p.390)*.
133. See C. Clarkson, "Context and Culpability in Involuntary Manslaughter" in A. Ashworth and B. Mitchell (eds), *Rethinking English Homicide Law* (Oxford: Oxford University Press, 2000).
134. *Garg [2012] EWCA Crim 2520; [2013] 2 Cr. App. R. (S.) 30 (p.203)* at [24].
135. *Attorney General's Reference No.111 of 2006 [2006] EWCA Crim 3269; [2007] 2 Cr. App. R. (S.) 26*.
136. *Attorney General's Reference (No.134 of 2004) [2004] EWCA Crim 3286; [2005] 2 Cr. App. R. (S.) 47 (p.284)*.
137. *Attorney General's Reference No.86 of 2006 (Michael Philip Shaw) [2006] EWCA Crim 2570; [2007] 1 Cr. App. R. (S.) 101*.
138. *Garg [2012] EWCA Crim 2520; [2013] 2 Cr. App. R. (S.) 30 (p.203)* at [4]-[46].
139. *Kite [1996] 2 Cr. App. R. (S.) 295*.
140. *Garg [2012] EWCA Crim 2520; [2013] 2 Cr. App. R. (S.) 30 (p.203)* at [17].
141. R. Francis, press release on publication of the Inquiry Report, available at: <http://www.midstaffsinquiry.com/pressrelease.html> [Accessed August 20, 2013].
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143. Quick, "Medicine, Mistakes and Manslaughter" (2010) 69 *C.L.J.* 186, 187.
144. Brazier and Alghrani, "Fatal Medical Malpractice and Criminal Liability" (2009) 25(2) *Journal of Professional Negligence* 51, 52.
145. See Quick, "Medicine, Mistakes and Manslaughter" (2010) 69 *C.L.J.* 186, 195.
146. *R. (on the application of Purdy) v DPP [2009] UKHL 45; [2009] 3 W.L.R. 403*.
147. Quick, "Medicine, Mistakes and Manslaughter" (2010) 69 *C.L.J.* 186, 190.
148. Mitchell and MacKay, "Investigating Involuntary Manslaughter: An Empirical Study of 127 Cases" (2011) 31 *O.J.L.S.* 165, 190. See also *Law Commission, A New Homicide Act for England and Wales? A Consultation Paper* (London: TSO, 2005), *Law Com. No.177, para.2.63*.
149. D. Thomas, "Case Comment Sentencing: Manslaughter by Gross Negligence" [2005] *Crim. L.R.* 323, 329.
150. [Criminal Appeal Act 1995 s.13](#).

[151.](#) J. Cooper, "The Sentencing Guidelines Council—A Practical Perspective" [2008] Crim. L.R. 277, 278.

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